Date:_____
Patient #:_____
S.S #:_____

IMMUNIZATION RECORD

VIRGINIA DEPARTMENT OF HEALTH

Name:_____ **DOB:**_____

	DATE	DATE	DATE	DATE	DATE
Diphtheria/Tetanus/ Pertussis (DTP)	____	____	____	____	____
Diphtheria/Tetanus (DT or Adult Td)	____	____	____	____	____
Poliomyelitis (OPV or eIPV)	____	____	____	____	____
Measles (Rubeola)	____	____	____	____	____
Rubella	____	____	____	____	____
Mumps	____	____	____	____	____
Measles, Mumps, Rubella (MMR)	____	____	____	____	____
Hepatitis B Vaccine	____	____	____	____	____
Haemophilus Influenza type b (Hib)	____	____	____	____	____

Serological Confirmation of Measles Immunity ____

Serological Confirmation of Rubella Immunity ____

*Child Entered School Before 08/01/81 ____
*(Mumps vaccine is not required if the child entered school before 08/01/81)

This is an official replication of the vaccination record for the above patient. Dates of immunizations listed above are either dates of vaccinations given or dates recorded with the Virginia Department of Health by the Patient.

_____ _____
Public Health Official Date

MCH 213C-SUPPLEMENT